STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. BUILDING _____ B. WING _____	R-C 01/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENSSELAER CARE CENTER	1309 E GRACE ST RENSSELAER, IN 47978

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00099598 and IN00099610 investigated on 11/29/11. This visit was in conjunction with the Investigation of Complaint IN00101575. Complaints IN00099598 and IN00099610 - corrected. Survey dates: January 3 and 4, 2012 Facility number: 000185 Provider number: 155287 AIM number: 100290840 Survey team: Regina Sanders, RN, TC Marcia Mital, RN Census bed type: SNF/NF: 101 Total: 101 Census Payor type: Medicare: 16 Medicaid: 73 Other: 12 Total: 101 Sample: 13 Rensselaer Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00099598 and IN00099610.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. BUILDING _____ B. WING _____	R-C 01/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENSSELAER CARE CENTER	**1309 E GRACE ST RENSSELAER, IN 47978**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review 1/05/12 by Suzanne Williams, RN	{F 000}		